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SALESFORCE.COM, INC.

UNITED STATES DISTRICT COURT

NORTHERN DISTRICT OF CALIFORNIA

SAN FRANCISCO DIVISION

STEVEN L. LORAIN,

Plaintiff,

vs.

SALESFORCE.COM, INC.,

Defendant.

Case No. C11-4934 EMC

DECLARATION OF ALICE VICHAITA IN SUPPORT OF OPPOSITION TO MOTION FOR DECLARATORY JUDGMENT

Date: December 2, 2011
Time: 1:30 p.m.
Courtroom: 5
Judge: Hon. Edward M. Chen

COMPLAINT FILED: October 5, 2011
TRIAL DATE: No date set.

I, ALICE VICHAITA, hereby declare and state:

1. I am employed by salesforce.com in the position of Benefits Manager. I have held my current position since September 1, 2010 and have been employed with salesforce.com since December 18, 2006. As Benefits Manager, I am responsible for the management of the salesforce.com Benefits Department, which administers benefit programs for salesforce.com employees, including health plans and leaves of absence. I am personally familiar with salesforce.com's personnel practices related to the creation and preservation of the types of documents referred to in this declaration.

2. Plaintiff Steven Lorain was hired by salesforce.com on August 7, 2006 and left work on a medical leave of absence on or about January 20, 2010.

3. On or about March 18, 2010 Plaintiff returned to work from his leave of absence and subsequently went back on a leave of absence on or about April 2, 2010.

4. On April 28, 2010, after 12 workweeks on leave of absence, Plaintiff exhausted his protected status under the Family and Medical Leave Act (FMLA) and the California Family Rights Act (CFRA). On April 29, 2010, he began an unpaid personal leave of absence which was anticipated by him and/or his doctor to be for a period of two to three months. Over the next 16 months, Plaintiff's leave of absence was repeatedly extended by salesforce.com based on notes from Plaintiff's doctor.

5. Salesforce.com provides group health insurance coverage to all regular full-time employees through the Open Choice Medical Plan, a self-insured plan administered by Aetna. A true and correct copy of excerpts from the Open Choice Medical Plan Booklet-Certificate is attached hereto as Exhibit A. Eligibility is described at page 4, loss of coverage at page 59 and COBRA rights at page 62. Plaintiff was enrolled in the Open Choice plan.

6. It is the policy and practice of salesforce.com to continue health benefits during an employee's protected FMLA/CFRA leave and for 31 days after the employee exhausts FMLA/CFRA leave. Employees on a non-protected leave receive company provided health coverage for only the first 30 days of that leave.

7. Plaintiff's 31 days of additional health benefits following his exhaustion of FMLA/CFRA leave was due to expire on May 29, 2010. Salesforce.com's normal practice is to send a letter to an employee on leave advising him that his benefits are about to expire, but because this was inadvertently not done in Plaintiff's case, salesforce.com notified Plaintiff on June 8, 2010 that it was extending his medical coverage through June 30, 2010. With the June 8, 2010 letter salesforce.com enclosed a notice to Plaintiff advising him of his right to continue his medical coverage under COBRA effective July 1, 2010 and a COBRA election form. A true and correct copy of salesforce's June 8, 2010 letter to Plaintiff and the enclosed COBRA notice and election form is attached hereto as Exhibit B.

LITTLER MENDELSON, P.C.
A Professional Corporation
650 California Street
20th Floor
San Francisco, CA 94108 2693
415.433 1940

8. On or about June 26, 2010 Plaintiff returned his COBRA election, a true and correct copy of which is attached as Exhibit C. Pursuant to his election, Plaintiff began COBRA coverage on July 1, 2010. His 18 months of coverage will end on December 31, 2011.

9. By letter dated August 9, 2011, salesforce.com advised Plaintiff that it would not grant a further extension of his leave of absence. A true and correct copy of this letter is attached hereto as Exhibit D.

10. Plaintiff's employment with salesforce.com was terminated effective on or about August 12, 2011. A true and correct copy of the termination letter is attached hereto as Exhibit E. Exhibit E a standard termination form letter that was used by salesforce.com at that time. One paragraph in the letter stated that "Your current health insurance benefits will continue until the end of the month that you terminate employment" and that the recipient would have the right to elect COBRA at his own cost. However, this paragraph did not apply to Plaintiff because his company benefits had already ended and he was already on COBRA. Plaintiff was not provided with a COBRA notice or election form following his termination.

11. To date, salesforce.com has not received a notice that the Social Security Administration has determined Plaintiff to be disabled.

12. I have personal knowledge of the policies and procedures governing creation and maintenance of the documents attached to this declaration as exhibits. The documents attached hereto were made and kept in the course of regularly conducted business activities pursuant to established company procedures for the routine and timely making and preserving of company records, and were relied upon by salesforce.com in its business activities.

13. The representations contained on the documents attached hereto were made in and as part of the regular course of business pursuant to salesforce.com's regular practices and based on the personal knowledge or information from a person with personal knowledge. The representations were made by persons acting routinely, under a duty of accuracy, for the purpose of salesforce.com's reliance thereon.

14. Pursuant to salesforce.com's practice, the documents attached hereto were made at or near the time of the event recorded therein.

I declare under penalty of perjury, under the laws of the United States and the State of California, that the foregoing is true and correct either of my personal knowledge or based on the business records of salesforce.com.

Executed this 11th day of November at San Francisco, California.

ALICE VICHAITA

Firmwide:105090371.1 068297.1003

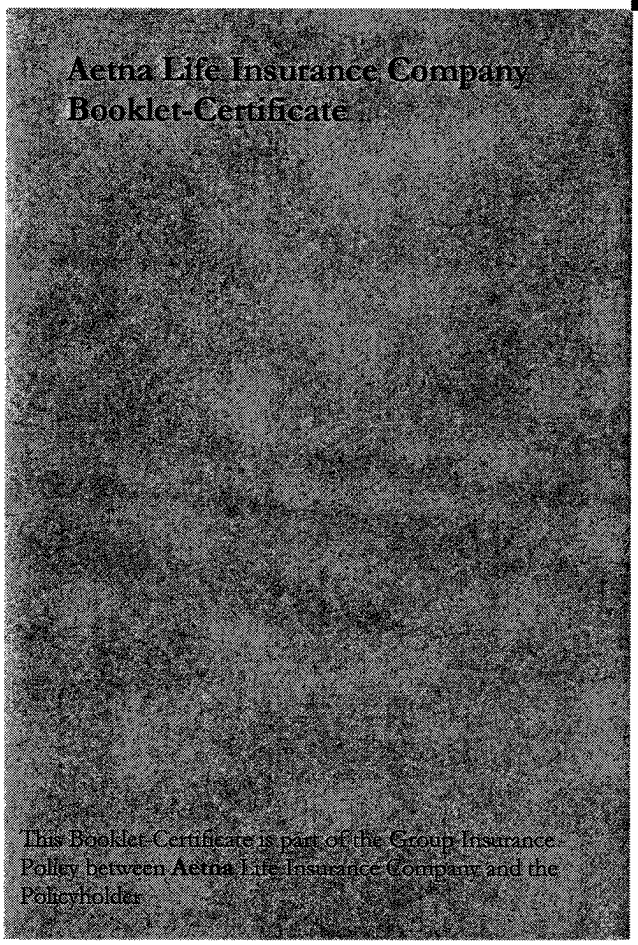
EXHIBIT A

BENEFIT PLAN

[redacted]

Prepared Exclusively for
salesforce.com

Open Choice Medical Plan



We want you to know℠

Aetna®

Table of Contents

*Defines the Terms Shown in Bold Type in the Text of This Document.

Preface *(GR-9N-02-005-03 CA)*

Aetna Life Insurance Company (ALIC) is pleased to provide you with this *Booklet-Certificate.* Read this *Booklet-Certificate* carefully. This insurance is underwritten by Aetna Life Insurance Company of Hartford, Connecticut (referred to as **Aetna**).

This *Booklet-Certificate* is part of the *Group Insurance Policy* between Aetna Life Insurance Company and the Policyholder. The *Group Insurance Policy* determines the terms and conditions of coverage. **Aetna** agrees with the Policyholder to provide coverage in accordance with the conditions, rights, and privileges as set forth in this *Booklet-Certificate.* The Policyholder selects the insurance products and benefit levels under the plan. Throughout this insured Booklet-Certificate, they may be referred to as "the Plan" or "this Plan". A person covered under this plan and their covered dependents are subject to all the conditions and provisions of the *Group Insurance Policy.*

The *Booklet-Certificate* describes the rights and obligations of you and **Aetna**, what the plan covers and how benefits are paid for that coverage. It is your responsibility to understand the terms and conditions in this *Booklet-Certificate.* Your *Booklet-Certificate* includes the *Schedule of Benefits* and any amendments or riders.

If you become insured, this *Booklet-Certificate* becomes your *Certificate of Coverage* under the *Group Insurance Policy*, and it replaces and supersedes all certificates describing similar coverage that **Aetna** previously issued to you.

Group Policyholder:	salesforce.com
Group Policy Number:	GP-883528
Effective Date:	January 1, 2010
Issue Date:	March 22, 2010
Booklet-Certificate Number:	2

WARNING:

THE INSURANCE DESCRIBED IN THIS BOOKLET-CERTIFICATE IS A PREFERRED PROVIDER ORGANIZATION. ANY COVERED DEPENDENT WILL BE COVERED FOR BOTH PREFERRED AND NON-PREFERRED BENEFITS REGARDLESS OF WHERE THEY RESIDE. **EMERGENCY CARE**, HOWEVER, WILL BE PAID AT THE PREFERRED LEVEL.

NOT ALL OF THE COVERED SERVICES OFFERED AT THE PREFERRED LEVEL MAY BE PROVIDED IF THEY ARE RECEIVED FROM A NON-PREFERRED PROVIDER. ALSO, ANY SERVICES PROVIDED BY A NON-PREFERRED PROVIDER WILL BE PAID AT A LOWER PERCENTAGE AND MAY BE SUBJECT TO A LOWER NUMBER OF DAYS/VISTS LIMITATION, LOWER MAXIMUM BENEFITS, HIGHER OUT-OF-POCKET LIMIT AND A HIGHER DEDUCTIBLE.

PLEASE REFER TO THE *GLOSSARY* FOR A DEFINITION OF YOUR **SERVICE AREA**.

A LISTING OF ALL **PREFERRED PROVIDERS** IN YOUR **SERVICE AREA** MAY BE ACCESSED AT ANY TIME BY VISITING WWW.AETNA.COM AND SELECTING "FIND A DOCTOR".

NOTICE

If you have a complaint because you are unable to access medical care in a timely manner, you may contact **Aetna's** Customer Service at the number shown on your ID card or you may write to us at:

Customer Service
Aetna Life Insurance Company
151 Farmington Avenue
Hartford CT 06156

or you may contact:

California Department of Insurance
Consumer Services Division
300 Spring Street
South Tower
Los Angeles CA 90013
1-800-927-HELP
1-800-927-4357

Ronald A. Williams
Chairman, Chief Executive Officer and President

Aetna Life Insurance Company
(A Stock Company)

Important Information Regarding Availability of Coverage *(GR-9N 02-005 02)*

No services are covered under this *Booklet-Certificate* in the absence of payment of current premiums subject to the *Grace Period* and the *Premium* section of the *Group Insurance Policy*.

Unless specifically provided in any applicable termination or continuation of coverage provision described in this *Booklet-Certificate* or under the terms of the *Group Insurance Policy*, the plan does not pay benefits for a loss or claim for a health care, medical or dental care expense incurred before coverage starts under this plan.

This plan will not pay any benefits for any claims, or expenses incurred after the date this plan terminates.

This provision applies even if the loss, or expense, was incurred because of an **accident, injury** or **illness** that occurred, began or existed while coverage was in effect.

Please refer to the sections, "*Termination of Coverage (Extension of Benefits)*" and "*Continuation of Coverage*" for more details about these provisions.

Benefits may be modified during the term of this plan as specifically provided under the terms of the *Group Insurance Policy* or upon renewal. If benefits are modified, the revised benefits (including any reduction in benefits or elimination of benefits) apply to any expenses incurred for services or supplies furnished on or after the effective date of the plan modification. There is no vested right to receive any benefits described in the *Group Insurance Policy* or in this *Booklet-Certificate* beyond the date of termination or renewal including if the service or supply is furnished on or after the effective date of the plan modification, but prior to your receipt of amended plan documents.

This Booklet-Certificate describes a medical plan of your Employer. However, you will only be considered to be enrolled in the plan(s) which you have elected and for which you have agreed to make contributions. Disregard the plan information for which you have not enrolled or agreed to make contributions.

Although other benefits may be described in your Booklet-Certificate, only the benefits outlined in this Booklet-Certificate for the plan in which you are enrolled apply to you and your eligible dependents.

Coverage for You and Your Dependents

Health Expense Coverage

Benefits are payable for covered health care expenses that are incurred by you or your covered dependents while coverage is in effect. An expense is "incurred" on the day you receive a health care service or supply.

Coverage under this plan is non-occupational. Only **non-occupational injuries** and **non-occupational illnesses** are covered.

Refer to the *What the Plan Covers* section of the *Booklet-Certificate* for more information about your coverage.

Treatment Outcomes of Covered Services

Aetna is not a provider of health care services and therefore is not responsible for and does not guarantee any results or outcomes of the covered health care services and supplies you receive. Except for Aetna RX Home Delivery LLC, providers of health care services, including hospitals, institutions, facilities or agencies, are independent contractors and are neither agents nor employees of **Aetna** or its affiliates.

When Your Coverage Begins

(GR-9N 29-005-01 CA)

Throughout this section you will find information on who can be covered under the plan, how to enroll and what to do when there is a change in your life that affects coverage. In this section, "you" means the employee.

Who Can Be Covered

Employees

To be covered by this plan, the following requirements must be met:

- You will need to be in an "eligible class", as defined below; and
- You will need to meet the "eligibility date criteria" described below.

Determining if You Are in an Eligible Class

You are in an eligible class if:

- You are a regular full-time employee, as defined by your employer.

Determining When You Become Eligible

You become eligible for the plan on your eligibility date, which is determined as follows.

On the Effective Date of the Plan

If you are in an eligible class on the effective date of this plan, your coverage eligibility date is the effective date of the plan.

After the Effective Date of the Plan

If you are hired after the effective date of this plan, your coverage eligibility date is the date you are hired.

If you enter an eligible class after the effective date of this plan, your coverage eligibility date is the date you enter the eligible class.

Obtaining Coverage for Dependents *(GR-9N 29-010 01)*

Your dependents can be covered under your plan. You may enroll the following dependents:

- Your legal spouse; or
- Your domestic partner who meets the rules set by your employer as outlined in the *Coverage for Domestic Partners* section following; and
- Your dependent children.

Aetna will rely upon your employer to determine whether or not a person meets the definition of a dependent for coverage under the plan. This determination will be conclusive and binding upon all persons for the purposes of this plan.

Coverage for Domestic Partner *(GR-9N 29-010 01)*
To be eligible for coverage, you and your domestic partner will need to:

- meet the requirements under California law for entering into a domestic partnership; and
- are "domestic partners" as determined in accordance with rules set by your Employer.

Coverage for Dependent Children *(GR-9N 29-010-02 CA)*
To be eligible, a dependent child must be:

- Unmarried; and
- Under 19 years of age; or
- Under age 25, as long as he or she is a full-time student at an accredited institution of higher education and solely depends on your support*.

*Note: Proof of full-time student status is required each year. This means that the child is enrolled as an undergraduate student with a total course load of at least 12 credits or is enrolled as a graduate student with a total course load of at least 9 credits.

An eligible dependent child includes: *(GR-9N 29-010-02 CA)*

- Your biological children;
- Your stepchildren;
- Your legally adopted children;
- Children under the age of 18 who are placed with you for adoption;
- Any physically or mentally disabled child, regardless of age, whose coverage was continued under your former plan of insurance that was in effect on the day before the effective date of this coverage;
- Your foster children;
- Any children for whom you are responsible under court order;
- Your grandchildren in your court-ordered custody; and
- Any other child who lives with you in a parent-child relationship.

Coverage for a physically or mentally disabled child may be continued past the age limits shown above. See *Physically or Mentally Disabled Dependent Children* for more information.

Important Reminder
Keep in mind that you cannot receive coverage under the plan as:

- Both an employee and a dependent; or
- A dependent of more than one employee.

How and When to Enroll *(GR-9N 29-015-02)*

Initial Enrollment in the Plan

You will be provided with plan benefit and enrollment information when you first become eligible to enroll. You will need to enroll in a manner determined by **Aetna** and your employer. To complete the enrollment process, you will need to provide all requested information for yourself and your eligible dependents. You will also need to agree to make required contributions for any contributory coverage. Your employer will determine the amount of your plan contributions, which you will need to agree to before you can enroll. Your employer will advise you of the required amount of your contributions and will deduct your contributions from your pay. Remember plan contributions are subject to change.

You will need to enroll within 31 days of your eligibility date. Otherwise, you may be considered a Late Enrollee. If you miss the enrollment period, you will not be able to participate in the plan until the next annual enrollment period,

unless you qualify under a Special Enrollment Period, as described below.

If you do not enroll for coverage when you first become eligible, but wish to do so later, your employer will provide you with information on when and how you can enroll.

Newborns are automatically covered for 31 days after birth. To continue coverage after 31 days, you will need to complete a change form and return it to your employer within the 31-day enrollment period.

Late Enrollment

If you do not enroll during the Initial Enrollment Period, or a subsequent annual enrollment period, you and your eligible dependents may be considered **Late Enrollees** and coverage may be deferred until the next annual enrollment period, but in no event will coverage be deferred for more than 12 months from the date of your application for coverage. If, at the time of your initial enrollment, you elect coverage for yourself only and later request coverage for your eligible dependents, they may be considered **Late Enrollees**.

You must return your completed enrollment form before the end of the next annual enrollment period.

Late Enrollees are subject to the Preexisting Condition Limitation.

However, you and your eligible dependents may not be considered **Late Enrollees** under the circumstances described in the "Special Enrollment Periods" section below.

Annual Enrollment

During the annual enrollment period, you will have the opportunity to review your coverage needs for the upcoming year. During this period, you have the option to change your coverage. The choices you make during this annual enrollment period will become effective the following year.

If you do not enroll yourself or a dependent for coverage when you first become eligible, but wish to do so later, you will need to do so during the next annual enrollment period, unless you qualify under one of the Special Enrollment Periods, as described below.

Special Enrollment Periods

You will not be considered a **Late Enrollee** if you qualify under a Special Enrollment Period as defined below. If one of these situations applies, you may enroll before the next annual enrollment period.

Loss of Other Health Care Coverage

You or your dependents may qualify for a Special Enrollment Period if:

- You did not enroll yourself or your dependent when you first became eligible or during any subsequent annual enrollments because, at that time:
  - You or your dependents were covered under other **creditable coverage**; and
  - You refused coverage and stated, in writing, at the time you refused coverage that the reason was that you or your dependents had other **creditable coverage**; and
- You or your dependents are no longer eligible for other **creditable coverage** because of one of the following:
  - The end of your employment;
  - A reduction in your hours of employment (for example, moving from a full-time to part-time position);
  - The ending of the other plan's coverage;
  - Death;
  - Divorce or legal separation;
  - Employer contributions toward that coverage have ended;
  - COBRA coverage ends;
  - the employer's decision to stop offering the group health plan to the eligible class to which you belong;

  - cessation of a dependent's status as an eligible dependent as such is defined under this Plan; or
  - you or your dependents have reached the lifetime maximum of another Plan for all benefits under that Plan.
- You will need to enroll yourself or a dependent for coverage within 31 days of when other **creditable coverage** ends. Evidence of termination of **creditable coverage** must be provided to **Aetna**. If you do not enroll during this time, you will need to wait until the next annual enrollment period.

New Dependents

You and your dependents may qualify for a Special Enrollment Period if:

- You did not enroll when you were first eligible for coverage; and
- You later acquire a dependent, as defined under the plan, through marriage, birth, adoption, or placement for adoption; and
- You elect coverage for yourself and your dependent within 31 days of acquiring the dependent.

Your spouse or child who meets the definition of a dependent under the plan may qualify for a Special Enrollment Period if:

- You did not enroll them when they were first eligible; and
- You later elect coverage for them within 31 days of a court order requiring you to provide coverage.

You will need to report any new dependents by completing a change form, which is available from your employer. The form must be completed and returned to **Aetna** within 31 days of the change. If you do not return the form within 31 days of the change, you will need to make the changes during the next annual enrollment period.

If You Adopt a Child

Your plan will cover a child who is placed for adoption. This means you have taken on the legal obligation for total or partial support of a child whom you plan to adopt.

Your plan will provide coverage for a child who is placed with you for adoption if:

- The child meets the plan's definition of an eligible dependent on the date he or she is placed for adoption; and
- You request coverage for the child in writing within 31 days of the placement.
- Proof of placement will need to be presented to **Aetna** prior to the dependent enrollment.
- Any coverage limitations for a pre-existing condition will not apply to a child placed with you for adoption provided that the placement occurs on or after the effective date of your coverage.

When You Receive a Qualified Child Support Order

A Qualified Medical Child Support Order (QMCSO) is a court order requiring a parent to provide health care coverage to one or more children. A Qualified Domestic Relations Support Order (QDRSO) is a court order requiring a parent to provide dependent's life insurance coverage to one or more children. Your plan will provide coverage for a child who is covered under a QMCSO or a QDRSO, if:

- The child meets the plan's definition of an eligible dependent; and
- You request coverage for the child in writing within 31 days of the court order.

Coverage for the dependent will become effective on the date of the court order. Any coverage limitations for a pre-existing condition will not apply, as long as you submit a written request for coverage within the 31-day period.

If you do not request coverage for the child within the 31-day period, you will need to wait until the next annual enrollment period.

Under a QMCSO or QDRSO, if you are the non-custodial parent, the custodial parent may file claims for benefits. Benefits for such claims will be paid to the custodial parent.

Prophylactic drugs for travel.

Refills in excess of the amount specified by the **prescription** order. Before recognizing charges, **Aetna** may require a new **prescription** or evidence as to need, if a **prescription** or refill appears excessive under accepted medical practice standards.

Refills dispensed more than one year from the date the latest **prescription** order was written, or as otherwise permitted by applicable law of the jurisdiction in which the drug is dispensed.

Replacement of lost or stolen **prescriptions**.

Drugs, services and supplies provided in connection with treatment of an **occupational injury or occupational illness**.

Smoking: Any treatment, drug, service or supply to stop or reduce smoking or the use of other tobacco products or to treat or reduce nicotine addiction, dependence or cravings, including, medications, nicotine patches and gum.

Strength and performance: Drugs or preparations, devices and supplies to enhance strength, physical condition, endurance or physical performance, including performance enhancing steroids.

Sex change: Any treatment, drug or supply related to changing sex or sexual characteristics, including hormones and hormone therapy.

Sexual dysfunction/enhancement: Any drug, or supply to treat sexual dysfunction, enhance sexual performance or increase sexual desire, including:

- Drugs, implants, devices or preparations to correct or enhance erectile function, enhance sensitivity, or alter the shape or appearance of a sex organ.

Supplies, devices or equipment of any type, except as specifically provided in the *What the Plan Covers* section.

Test agents except diabetic test agents.

When Coverage Ends *(GR-9N 30-005 01 CA) (GR-9N 30-005-HRP.A-CA)*

Coverage under your plan can end for a variety of reasons. In this section, you will find details on how and why coverage ends, and how you may still be able to continue coverage.

When Coverage Ends for Employees *(GR-9N 30-005 01 CA)*

Your coverage under the plan will end if:

- The plan is discontinued;
- You voluntarily stop your coverage;
- The group policy ends;
- You are no longer eligible for coverage;
- You do not make any required contributions;
- You become covered under another plan offered by your employer;

- You have exhausted your overall maximum lifetime benefit under your medical plan, if your plan contains such a maximum benefit; or
- Your employment stops. This will be either the date you stop active work, or the day before the first premium due date that occurs after you stop active work. However, if premium payments are made on your behalf, your coverage may continue until stopped by your employer as described below:
  - If you are not at work due to **illness or injury**, your coverage may continue, but not beyond the end of the next policy month after the policy month in which your absence started. A "policy month" is defined in the group policy on file with your employer.
  - If you are not at work due to temporary lay-off or leave of absence, your coverage will stop on your last full day of active work before the start of the lay-off or leave of absence.

It is your employer's responsibility to let **Aetna** know when your employment ends. The limits above may be extended only if **Aetna** and your employer agree, in writing, to extend them.

Aetna will notify your employer in writing of the cancellation of your group medical policy at least 30 days prior to the effective date of the termination. It is your employer's responsibility to promptly mail a copy of the notice of cancellation to you along with information regarding your conversion rights upon termination of the policy.

Your Proof of Prior Medical Coverage *(GR-9N 30-010 01-CA)*

Under the Health Insurance Portability and Accountability Act of 1996, your employer is required to give you a certificate of **creditable coverage** when your employment ends. This certificate proves that you were covered under this plan when you were employed. Ask your employer about the certificate of **creditable coverage**.

When Coverage Ends for Dependents

Coverage for your dependents will end if:

- You are no longer eligible for dependents' coverage;
- You do not make the required contribution toward the cost of dependents' coverage;
- Your own coverage ends for any of the reasons listed under *When Coverage Ends* for Employees (other than exhaustion of your overall maximum lifetime benefit, if included);
- Your dependent is no longer eligible for coverage. In this case, coverage ends at the end of the calendar month when your dependent no longer meets the plan's definition of a dependent; or
- Your dependent becomes eligible for comparable benefits under this or any other group plan offered by your employer.

In addition, a "domestic partner" will no longer be considered to be a defined dependent on the earlier to occur of:

- The date this plan no longer allows coverage for domestic partners.
- The date of termination of the domestic partnership.

Coverage for dependents may continue for a period after your death. Coverage for handicapped dependents may continue after your dependent reaches any limiting age. See *Continuation of Coverage* for more information.

Continuation of Coverage *(GR-9N 31-010 03)*

Continuing Health Care Benefits *(GR-9N 31-015 01) (GR9N DEP30)*

Physically or Mentally Disabled Dependent Children *(GR-9N 31-015 03-CA)*

Health Expense Coverage for your physically or mentally dependent child may be continued past the maximum age for a dependent child. However, Health Expense Coverage may not be continued if the child has been issued an individual medical conversion policy.

Your child is physically or mentally disabled if:

- He or she is not able to earn his or her own living because of a physical or mentally disabling injury, illness, or condition which started prior to the date he or she reaches the maximum age for dependent children under your plan; and
- He or she depends chiefly on you for support and maintenance.

Proof that your child has a physical or mentally disabling injury, illness, or condition must be submitted to Aetna no later than 90 days from the date you receive a written notice from Aetna that your child is approaching the maximum age under your plan.

Coverage will cease on the first to occur of:

- Cessation of the physical or mentally disabling injury, illness, or condition.
- Failure to give proof that the physical or mentally disabling injury, illness, or condition continues.
- Failure to have any required exam.
- Termination of Dependent Coverage as to your child for any reason other than reaching the maximum age under your plan.

Aetna will have the right to:

- Require proof of the continuation of the physical or mentally disabling injury, illness, or condition; and
- Examine your child at its own expense, while the physical or mentally disabling injury, illness, or condition continues; but not more frequently than once each year after the two-year period following the date your child reached the maximum age under your plan.

Continuation of Coverage Under California Law After COBRA Coverage is Exhausted *(GR-9N 31-025 01 CA)*

In accordance with California law, if you continued Health Expense Coverage under this Plan in accordance with federal law (PL 99-272-COBRA) for the maximum period for which such continuation is available to you, and if such maximum period is less than 36 months, you may, prior to the date coverage continuation under COBRA terminates, elect to further continue the same Health Expense Coverage for up to 36 months from the date your COBRA continuation of coverage began.

The election must include an agreement to pay premiums. The premiums may be up to 110% of the cost of the Plan (up to 150% if you are disabled pursuant to Title II or Title XVI of the Social Security Act). Premium payments must be continued.

You must elect to continue coverage within 60 days of the later to occur of the date coverage would terminate and the date **Aetna** informs you of any rights under this section. Within 45 days of such election, you must send to **Aetna** the amount required by **Aetna** as the first premium payment.

Coverage will terminate on whichever of the following is the earliest to occur:

- 36 months after your COBRA continuation period began. However, if you have been determined to have been disabled under Title II or Title XVI of the Social Security Act at any time during the first 60 days of continuation coverage, you must provide notice to your Employer within 60 days of such determination and prior to the end of the 36 month continuation period. Coverage may only be continued if you are determined to be disabled.
- The date that the group contract discontinues in its entirety as to health expense coverage. However, continued coverage will be available to you under another plan sponsored by your Employer.
- The date any required contributions are not made.

- The first day after the date of the election that you are covered under another group health plan. However, continued coverage will not terminate under such time that you are no longer affected by a preexisting condition exclusion or limitation under such other group health plan.
- The date you become entitled to benefits under Medicare. This will not apply if contrary to the provisions of the Medicare Secondary Payer Rules or other federal law.
- The month that begins more than 31 days after the date of the final determination under Title II or Title XVI of the Social Security Act that you are no longer disabled.

The Conversion Privilege will be available when coverage is no longer available under this section.

Extension of Benefits *(GR-9N 31-020 01-CA)*

Coverage for Health Benefits

If your health benefits end while you are totally disabled, your health expenses will be extended as described below. To find out why and when your coverage may end, please refer to *When Coverage Ends.*

"Totally disabled" means that because of an **injury** or **illness** you are not able to:

- Perform with reasonable continuity all of the material duties necessary to pursue your own occupation in the usual and customary way; or
- Engage with reasonable continuity in another occupation in which you could reasonably be expected to perform satisfactorily in light of your age, education, training, experience, station in life, physical and mental capacity.

Extended Health Coverage *(GR-9N 31-020 01-CA)*

Medical Benefits (other than Basic medical benefits): Coverage will be available while you are totally disabled, for up to 12 months.

Prescription Drug Benefits: Coverage will be available while you are totally disabled for up to 12 months.

When Extended Health Coverage Ends

Extension of benefits will end on the first to occur of the date:

- You are no longer totally disabled, or become covered under any other group plan with like benefits.
- Your dependent is no longer totally disabled, or he or she becomes covered under any other group plan with like benefits.

(This does not apply if coverage ceased because the benefit section ceased for your eligible class.)

Important Note
If the Extension of Benefits provision outlined in this section applies to you or your covered dependents, see the *Converting to an Individual Health Insurance Policy* section for important information.

COBRA Continuation of Coverage *(GR-9N 31-025 01 CA)*

If your employer is subject to COBRA requirements, the health plan continuation is governed by the Federal Consolidated Omnibus Budget Reconciliation Act of 1985 (COBRA) requirements. With COBRA you and your dependents can continue health coverage, subject to certain conditions and your payment of premiums. Continuation rights are available following a "qualifying event" that would cause you or family members to otherwise lose coverage. Qualifying events are listed in this section.

Continuing Coverage through COBRA

When you or your covered dependents become eligible, your employer will provide you with detailed information on continuing your health coverage through COBRA.

You or your dependents will need to:

- Complete and submit an application for continued health coverage, which is an election notice of your intent to continue coverage.
- Submit your application within 60 days of the qualifying event, or within 60 days of your employer's notice of this COBRA continuation right, if later.
- Agree to pay the required premiums.

Who Qualifies for COBRA

You have 60 days from the qualifying event to elect COBRA. If you do not submit an application within 60 days, you will forfeit your COBRA continuation rights.

Below you will find the qualifying events and a summary of the maximum coverage periods according to COBRA requirements.

Qualifying Event Causing Loss of Health Coverage	Covered Persons Eligible to Elect Continuation	Maximum Continuation Periods
Your active employment ends for reasons other than gross misconduct	You and your dependents	18 months
Your working hours are reduced	You and your dependents	18 months
Your marriage is annulled, you divorce or legally separate and are no longer responsible for dependent coverage	Your dependents	36 months
You become entitled to benefits under Medicare	Your dependents	36 months
Your covered dependent children no longer qualify as dependents under the plan	Your dependent children	36 months
You die	Your dependents	36 months
You are a retiree eligible for health coverage and your former employer files for bankruptcy	You and your dependents	18 months

Disability May Increase Maximum Continuation to 29 Months

If You or Your Covered Dependents Are Disabled.

If you or your covered dependent qualify for disability status under Title II or XVI of the Social Security Act during the 18 month continuation period, you or your covered dependent:

- Have the right to extend coverage beyond the initial 18 month maximum continuation period.
- Qualify for an additional 11 month period, subject to the overall COBRA conditions.
- Must notify your employer within 60 days of the disability determination status and before the 18 month continuation period ends.
- Must notify the employer within 30 days after the date of any final determination that you or a covered dependent is no longer disabled.
- Are responsible to pay the premiums after the 18th month, through the 29th month.

If There Are Multiple Qualifying Events.

A covered dependent could qualify for an extension of the 18 or 29 month continuation period by meeting the requirements of another qualifying event, such as divorce or death. The total continuation period, however, can never exceed 36 months.

Determining Your Premium Payments for Continuation Coverage

Your premium payments are regulated by law, based on the following:

- For the 18 or 36 month periods, premiums may never exceed 102 percent of the plan costs.
- During the 18 through 29 month period, premiums for coverage during an extended disability period may never exceed 150 percent of the plan costs.

When You Acquire a Dependent During a Continuation Period

If through birth, adoption or marriage, you acquire a new dependent during the continuation period, your dependent can be added to the health plan for the remainder of the continuation period if:

- He or she meets the definition of an eligible dependent,
- Your employer is notified about your dependent within 31 days of eligibility, and
- Additional premiums for continuation are paid on a timely basis.

Important Note
For more information about dependent eligibility, see the *Eligibility, Enrollment and Effective Date* section.

When Your COBRA Continuation Coverage Ends

Your COBRA coverage will end when the first of the following events occurs:

- You or your covered dependents reach the maximum COBRA continuation period – the end of the 18, 29 or 36 months. (Coverage for a newly acquired dependent who has been added for the balance of a continuation period would end at the same time your continuation period ends, if he or she is not disabled nor eligible for an extended maximum).
- You or your covered dependents do not pay required premiums.
- You or your covered dependents become covered under another group plan that does not restrict coverage for pre-existing conditions. If your new plan limits pre-existing condition coverage, the continuation coverage under this plan may remain in effect until the pre-existing clause ceases to apply or the maximum continuation period is reached under this plan.
- The date your employer no longer offers a group health plan.
- The date you or a covered dependent becomes enrolled in benefits under Medicare. This does not apply if it is contrary to the Medicare Secondary Payer Rules or other federal law.
- You or your dependent dies.

Conversion from a Group to an Individual Plan

You may be eligible to apply for an individual health plan without providing proof of good health:

- At the termination of employment.
- When loss of coverage under the group plan occurs.
- When loss of dependent status occurs.
- At the end of the maximum health coverage continuation period.

The individual policy will not provide the same coverage as the former group plan offered by your employer. Certain benefits may not be available. You will be required to pay the associated premium costs for the coverage. For additional conversion information, contact your employer or call the toll-free number on your member ID card.

EXHIBIT B

salesforce.com
Success. Not Software.

June 8, 2010

Steve Lorain
432 Superior Way
Discovery Bay, CA 94514

RE: Request for Medical Leave

Dear Steve:

I hope this letter finds you on the way to recovery. This is to follow up from ou r conversation today and the messages I left you on May 28, 2010 & June 3, 2010. I have enclosed the letter I sent out on June 1, 2010, in which delivery was attempted on three different occasions. It grants an extension for your leave of absence through July 6, 2010, along with the updated COBRA information that is effective July 1, 2010.

Per our conversation and consistent to our Company Policy as set forth in the U.S. Addendum to the Global Employee Handbook, your benefits discontinued as of May 29, 2010, 31 days from when you had exhausted all leave to which you were entitled under the Family Medical Leave Act (FMLA) and California Family Rights Act (CFRA). At which time, the Company granted you a personal leave of absence through July 6, 2010. However, since you did not receive said letter we are happy to continue your benefits through June 30, 2010. Discontinuation of benefits has no impact on your employment with the Company and we look forward to your return to work.

Please let me know if there is anything else you need.

Sincerely,

Lourdes Razo
Employee Success Operations Generalist
Ph. 415.536.5211
eFax. 415.592.3272

Individual Billing
Administration - COBRA
151 Farmington Avenue, RW52
Hartford, CT 06156-7622
1-800-429-9526
TDB/TTY: 1-888-899-2562

STEVEN LORAIN
432 SUPERIOR WAY
DISCOVERY BAY , CA 94514

****Important Notice Regarding Your COBRA Continuation Coverage Rights ****

This notice contains important information about your right to continue your healthcare coverage. Through the Consolidated Omnibus Budget Reconciliation Act (COBRA), you may elect to continue your healthcare benefits for 18, 29, or 36 months (depending on your qualifying event) by paying the full cost, plus an administrative charge of 2%. [Please note: If you are enrolled in a Healthcare Flexible Spending Account (FSA) and wish to continue it with COBRA, it may usually only be continued through the end of the current plan year on an after tax basis.]

The American Recovery and Reinvestment Act of 2009 (ARRA), as amended by the Department of Defense Appropriations Act, 2010, the Temporary Extension Act of 2010 (TEA), and the Continuing Extension Act of 2010 (CEA), reduces the COBRA premium in some cases. You are receiving this election notice because you experienced a qualifying event that occurred during the period that begins with September 1, 2008 and ends with May 31, 2010 and you may be eligible for the temporary premium reduction for up to 15 months. To help determine whether you can get the ARRA premium reduction, you should read this notice and the attached documents carefully. In particular, reference the "Summary of the COBRA Premium Reduction Provisions under ARRA, as Amended" for details regarding eligibility, restrictions, and obligations and the "Application for Treatment as an Assistance Eligible Individual." If you believe you meet the criteria for the premium reduction, complete the "Application for Treatment as an Assistance Eligible Individual" and return it with your completed Election Form.

Currently you and/or your qualified beneficiaries are eligible for the coverage(s) indicated on the enclosed election notice. Each person is entitled to elect COBRA continuation coverage, which will continue group healthcare coverage under the Plan for up to 18, 29, or 36 months (depending on your qualifying event). If elected, COBRA continuation will begin on the day following the qualifying event date that is listed on the enclosed COBRA election form, regardless of when you become responsible for the full COBRA premium.

This coverage will be the same as that which is provided to active employees. However, you may continue the coverage that was in effect on your qualifying event date or reduce the number of participants electing COBRA.

Continuation of coverage under the Plan for eligible beneficiaries will end on the earliest of the following dates:

a. the date following your election date on which you become covered under another group health plan under which you are not subject to an preexisting conditions, limitations or exclusions, or the date you satisfied any such preexisting conditions, limitations or exclusions;
b. when you fail to make a timely premium payment;
c. when you reach the end of your maximum eligibility period;
d. the date you become entitled to Medicare coverage (after the date of your COBRA election);
e. the date on which your former employer ceases to provide the plan to all employees (See further details on enclosed materials).

To elect COBRA continuation coverage, please review the following pages and complete the 'Applicant Section' located at the bottom of the enclosed COBRA Continuation Coverage Election Notice. Upon completion please submit this election notice and your initial payment to us at:

Individual Billing Administration
151 Farmington Avenue, RW52
Hartford, CT 06156-7622

NOTE: Please allow 2 weeks for mailing and processing.

For COBRA continuation cost information please see the enclosed COBRA election notice for the applicable rates based on your current level of coverage. The initial premium payment must be made within 45 days after the date of the COBRA election by the qualified beneficiary. Payment generally must cover the period of coverage from the date of COBRA election retroactive to the date of the loss of coverage due to the qualifying event. If premiums are not paid by the first day of the period of coverage, claims will not be paid until premium payment is received. Premiums for successive periods of coverage are due on the date stated by the plan administrator with a minimum 30-day grace period for payments. Payment is considered to be made on the date it is sent to the plan administrator. Important additional information about payment for COBRA continuation is included in the enclosed materials.

For additional assistance you may also contact Individual Billing Administration at 1-800-429-9526, TDB/TTY: 1-888-899-2562, Monday through Friday 8:00 a.m. to 9:00 p.m. Eastern Time.

COBRA Group Health Benefits Right of Continuation Coverage Election Notice:

Continuation of Group Health coverage is available to you due to the following qualifying event which took effect on:

07/01/2010 Reduction in Hours

EMPLOYER SECTION: (Please provide the following information necessary to ensure proper processing of application.)

	Date of this Notice: 06/08/2010
To: Eligible Continuee Applicant's Name STEVEN LORAIN	From: (Employer) SALESFORCE.COM
Address 432 SUPERIOR WAY	COBRA Individual Billing Number: Control: *883528* Suffix: *10* Account: *001* Plan: *001M* Dental Plan
City: DISCOVERY State: CA Zip Code: 94514	
Applicant's Control/Suffix/Account under Aetna Group Plan	Date Group Insurance Terminates: Insurance Termination Date: *06/30/2010* Dental Termination Date (if different):

To elect COBRA continuation coverage, this election form must be completed, returned by mail to the return address on your cover letter, and post marked no later than 08/29/2010

If you do not submit this completed election form by the date indicated above you may lose your right to elect COBRA continuation coverage. If you do not elect COBRA continuation coverage prior to the date indicated above you may change your mind as long as you furnish this completed election form before the date indicated above. However, if you change your mind after first rejecting COBRA continuation coverage your COBRA continuation will begin on the date you furnis the completed election form.

The initial premium payment must be made within 45 days after the date of the COBRA election by the qualified beneficiary. Payment generally must cover the period of coverage from the date of COBRA election retroactive to the date of the loss of coverage due to the qualifying event. If premiums are not paid by the first day of the period of coverage, claims will not be processed until premium payment is received. Premiums for successive periods of coverage are due on the date stated by the plan administrator with a minimum 30 day grace period for payments. Payment is considered to be made on the date it is sent to the plan administrator.

		Rate	Plan	Coverage as of Qualifying Event		Other Rate	
MEDICAL	X	*467.24*	*AETNA OAMC*	*Insured Only*			
DENTAL	X	*43.30*	*DENTAL PPO*	*Insured Only*			
VISION	X	*6.39*	*VISION*	*Insured Only*			
OTHER	X	*3.08*	*ASH MASSAGE THERAPY*				
OTHER							
FSA			*FSA Monthly Contribution*				
Monthly Cost is:		*$520.01*	**Note: This reflects the cost of all offered benefits.**				

Comments:

Rates are subject to change periodically. Any adjustments in premium will be reflected on your next monthly statement. **After the initial payment you must submit the same monthly payment until you have been advised of a change. If you fail to make the monthly payment within 30 days of its due date, your coverage will cease on that date and cannot be reinstated.**

Your initial payment must cover the number of full months from the above insurance termination date through the date your payment is mailed.

MAKE CHECK OR MONEY ORDER PAYABLE TO: **AETNA**

APPLICANT SECTION: CONTINUATION COVERAGE ELECTION INFORMATION - *MUST BE COMPLETED*

1. Applicant's Name: (Last,First,Middle Init.)	2. Applicant's Social Security #:	3. Employee Social Security #:
4. Applicant's Address:	5. Applicant's Date of Birth:	6. Telephone #:

7. I request continuation of: ____Medical ____ Dental ____ Vision ____ Other____ Other ____ FSA Coverage is for: ____Self Only
____Self & Spouse ____Self & Child(ren)____Family ____Spouse & Child(ren)____ Self, Spouse & Child(ren)____ Child Only ____ Spouse Only

8. I am electing premium reduction through the ARRA: ___Yes ____ No

If coverage is not elected on behalf of any presently covered dependent, a separate copy of this notice will be sent to your present or former spouse, if any; otherwise, to each covered dependent or his/her legal representative for election if the proper name, relationship, mailing address is provided

Name:	Address:	Relationship:

9. All Individuals to be Covered:

Name	Relationship	Social Security Number	Date of Birth	Regularly Attending School (Y/N) *	Primary Care Physician #	Previously Seen? (Y/N)
	SELF					

* List the first name of dependent(s) and the name of the school being attended:

Applicant's Signature: _____ Election Date/Date Signed: _____

Company Code: Location Code:

Applicant's instructions for completion of "Applicant Section" of Enrollment form.

Item No. 1: Please fill in your name: (Last, First & Middle Initial).
Item No. 2: Fill in your Social Security Number.
Item No. 3: Fill in the Social Security Number of the employee who originally held the coverage under the group. This should be completed for all applicants other than the terminated employee.
Item No. 4: Fill in your full address.
Item No. 5: Fill in your birth date.
Item No. 6: Fill in a phone number where you can be reached.
Item No. 7: Enrollment coverages will be the same for all family members unless a separate request form is furnished.
Item No. 8: Indicate whether you are electing premium reduction through ARRA. Please Note: If you answered yes to this question, you must complete the enclosed "Request for Treatment as an Assistance Eligible Individual" form.
Item No. 9: List applicant's eligible dependents.

- The Name, Relationship, Social Security Number, and Birth Date of all eligible dependents should be listed. (If Managed Choice coverage is elected, the Primary Care Physician Number must also be listed.) These dependents must have been previously covered under the group.

- Indicate "Y" or "N" if the dependent(s) is a full time student. If so, list the dependent(s) and name of school(s) being attended.

- Indicate "Y" or "N" if the Primary Care Physician has previously been seen.

Sign and date the notice.

*REMINDER: THE CHECK FOR THIS INITIAL PAYMENT MUST COVER THE NUMBER OF FULL MONTHS FROM THE DATE GROUP INSURANCE TERMINATES (AS INDICATED ON THE ELECTION NOTICE) TO THE TIME OF YOUR PAYMENT.

IMPORTANT INFORMATION ABOUT YOUR COBRA CONTINUATION COVERAGE RIGHTS:

What is continuation coverage?

Federal law requires that most group health plans (including this Plan) give employees and their families the opportunity to continue their health care coverage when there is a "qualifying event" that would result in a loss of coverage under an employer's plan. Depending on the type of qualifying event, "qualified beneficiaries" can include the employee (or retired employee) covered under the group health plan, the covered employee's spouse, and the dependent children of the covered employee.

Continuation coverage is the same coverage that the Plan gives to other participants or beneficiaries under the Plan who are not receiving continuation coverage. Each qualified beneficiary who elects continuation coverage will have the same rights under the Plan as other participants or beneficiaries covered under the Plan, including special enrollment rights.

How long does the continuation last?

In the case of a loss of coverage due to end of employment or reduction in hours of employment, coverage generally may be continued only for up to a total of 18 months. In the case of loss of coverage due to an employee's death, divorce or legal separation, the employee's becoming entitled to Medicare benefits or a dependent child ceasing to be a dependent under the terms of the Plan, coverage may be continued for up to a total of 36 months. When the qualifying event is the end of employment or reduction of the employee's hours of employment, and the employee becomes entitled to Medicare benefits less than 18 months before the qualifying event, COBRA continuation coverage for qualified beneficiaries, other than the employee, lasts until 36 months after the date of Medicare entitlement. This notice shows the maximum period of continuation coverage available to the qualified beneficiaries.

Continuation coverage will be terminated before the end of the maximum period if:

- Any required premium is not paid in full on time;
- A qualified beneficiary becomes covered, after electing continuation coverage, under another group health plan that does not impose any pre-existing condition exclusion for a pre-existing condition of the qualified beneficiary;
- A qualified beneficiary becomes entitled to Medicare benefits (under Part A, Part B, or both) after electing continuation coverage, or
- The employer ceases to provide any group health plan for its employees.

Continuation coverage may also be terminated for any reason the Plan would terminate coverage of a participant or beneficiary not receiving continuation coverage (such as fraud).

How can you extend the length of COBRA continuation coverage?

If you elect continuation coverage, an extension of the maximum period of coverage may be available if a qualified beneficiary is disabled or a second qualifying event occurs. You must notify Individual Billing Administration of a disability or a second qualifying event in order to extend the period of continuation coverage. Failure to provide notice of a disability or second qualifying event may affect the right to extend the period of continuation coverage. Please send this notification to:

Individual Billing Administration
151 Farmington Avenue, RW52
Hartford, CT 06156-7622

Disability:
An 11-month extension of coverage may be available if any of the qualified beneficiaries is determined by the Social Security Administration (SSA) to be disabled. The disability has to have started at some time before the 60th day of COBRA continuation coverage and must last at least until the end of the 18-month period of continuation coverage. In order for your extension of benefits to be processed you must notify the plan administrator of the determination within 60 days of the determination and before the end of the original 18-month COBRA coverage period. Each qualified beneficiary who has elected continuation coverage will be entitled to the 11-month disability extension if one of them qualifies. If the qualified beneficiary is determined by SSA to no longer be disabled, you must notify the plan administrator of that fact within 30 days after SSA's determination.

Second Qualifying Event:
An 18-month extension of coverage will be available to spouses and dependent children who elect continuation coverage if a second qualifying event occurs during the first 18 months of continuation coverage. The maximum amount of continuation coverage available when a second qualifying event occurs is 36 months in total. Such second qualifying events may include the death of a covered employee, divorce or separation from the covered employee, the covered employee's becoming entitled to Medicare benefits (under Part A, Part B, or both), or a dependent child ceasing to be eligible for coverage as a dependent under the Plan. These events can be a second qualifying event only if they would have caused the qualified beneficiary to lose coverage under the Plan if the first qualifying event had not occurred. You must notify the plan administrator within 60 days after a second qualifying event occurs if you want to extend your continuation coverage.

How can you elect COBRA continuation coverage?
To elect continuation coverage, you must complete the Election Form and furnish it according to the directions on the form. Each qualified beneficiary has a separate right to elect continuation coverage. For example, the employee's spouse may elect continuation coverage even if the employee does not. Continuation coverage may be elected for only one, several, or all dependent children who are qualified beneficiaries. A parent may elect to continue coverage on behalf of any dependent children. The employee or the employee's spouse can elect continuation coverage on behalf of all of the qualified beneficiaries.

In considering whether to elect continuation coverage, you should take into account that a failure to continue your group health coverage will affect your future rights under federal law. First, you can lose the right to avoid having pre-existing condition exclusions applied to you by other group health plans if you have more than a 63-day gap in health coverage, and election of continuation coverage may help you not have such a gap. Second, you will lose the guaranteed right to purchase individual health insurance policies that do not impose such pre-existing condition exclusions if you do not get continuation coverage for the maximum time available to you. Finally, you should take into account that you have special enrollment rights under federal law. You have the right to request special enrollment in another group health plan for which you are otherwise eligible (such as a plan sponsored by your spouse's employer) within 30 days after your group coverage ends because of the qualifying event listed above. You will also have the same special enrollment right at the end of continuation coverage if you get continuation coverage for the maximum time available to you.

Can I convert to an Individual plan when my Continuation expires?
If any continuation ceases because of the 18, 29, or 36 month limit, you may be eligible for conversion of your Group Medical Expense Benefits (but not non-medical health coverage) to an individual policy, without medical examination, subject to the conversion privilege which may be contained in the group plan. If you wish to be insured under an individual medical policy, you must exercise your conversion privilege within 31 days after continuation ceases or within the time period required under the group plan. You may insure yourself alone or yourself and all dependents that are covered at that time.

Although the law allows you to complete and submit the conversion application any time within 180 days prior to the end of the 18, 29, or 36 month continuation period, the conversion policy can not become effective until the day following the date on which the above maximum period ends.

Please note: If you elect to convert to an individual medical Conversion Policy, your rights to be an "eligible individual" under the terms of the federal Health Insurance Portability and Accountability Act (HIPAA), for guaranteed issue of certain individual health coverage available in your state, will be forfeited.

If you are interested in taking advantage of this conversion privilege or receiving more details, please contact your insurance carrier directly. Please refer to your medical ID card for that contact information. You may not receive another notification of this option.

How much does COBRA continuation coverage cost?
Generally, each qualified beneficiary may be required to pay the entire cost of continuation coverage. The amount a qualified beneficiary may be required to pay may not exceed 102% (or, in the case of an extension of continuation coverage due to a disability, 150% of the cost to the group health plan including both employer and employee contributions) for coverage of a similarly situated plan participant or beneficiary who is not receiving continuation coverage. The required payment for each continuation coverage period for each option is described in this notice.

The American Recovery and Reinvestment Act of 2009, as amended by the Department of Defense Appropriations Act, 2010, the Temporary Extension Act of 2010, and the Continuing Extension Act of 2010 (CEA), reduces the COBRA premium in some cases. The premium reduction is available to certain individuals who experience a qualifying event relating to COBRA continuation coverage that is an involuntary termination of employment during the period beginning with September 1, 2008 and ending with May 31, 2010 or a reduction of hours during the period beginning with September 1, 2008 and ending with May 31, 2010 that is followed by an involuntary termination of employment on or after March 2, 2010 and by May 31, 2010. If you qualify for the premium reduction, you need only pay 35 percent of the COBRA premium otherwise due to the plan. This premium reduction is available for up to 15 months. If your COBRA continuation coverage lasts for more than 15 months, you will have to pay the full amount to continue your COBRA continuation coverage. See the attached "Summary of the COBRA Premium Reduction Provisions under ARRA, as Amended" for more details, restrictions, and obligations as well as the form necessary to establish eligibility.

The Trade Act of 2002 created a new tax credit for certain individuals who become eligible for trade adjustment assistance and for certain retired employees who are receiving pension payments from the Pension Benefit Guaranty Corporation (PBGC) (eligible individuals). Under the new tax provisions, eligible individuals can either take a tax credit or get advance payment of 65% of premiums paid for qualified health insurance, including continuation coverage. ARRA made several amendments to these provisions, including an increase in the amount of the credit to 80% of premiums for coverage before January 1, 2011 and temporary extensions of the maximum period of COBRA continuation coverage for PBGC recipients (covered employees who have a nonforfeitable right to a benefit any portion of which is to be paid by the PBGC) and TAA-eligible individuals. If you have questions about these new tax provisions, you may call the Health Coverage Tax Credit Customer Contact Center toll-free at 1-866-628-4282. TDD/TTY callers may call toll-free at 1-866-626-4282. More information about the Trade Act is also available at www.doleta.gov/tradeact.

When and how must payment for COBRA continuation coverage be made?
First payment for continuation coverage:

If you elect continuation coverage the initial premium payment must be made within 45 days after the date of the COBRA election by the qualified beneficiary. Payment generally must cover the period of coverage from the date of COBRA election (this is the date the Election Notice is postmarked, if mailed) retroactive to the date of the loss of coverage due to the qualifying event. If premiums are not paid by the first day of the period of coverage, claims will not be processed until premium payment is received. Premiums for successive periods of coverage are due on the date stated in the Plan with a minimum 30-day grace period for payments. Payment is considered to be made on the date it is sent to the plan administrator.

If you do not make your first payment for continuation coverage in full not later than 45 days after the date of your election, you will lose all continuation coverage rights under the Plan. You are responsible for making sure that the amount of your first payment is correct. You may contact the Individual Billing Unit at 1-800-429-9526, TDD/TTY: 1-888-899-2562, to confirm the correct amount of your first payment or to discuss payment issues related to the ARRA premium reduction.

Your first payment for continuation coverage should be sent to:

Individual Billing Administration
151 Farmington Avenue, RW52
Hartford, CT 06156-7622

Periodic payments for continuation coverage:

After you make your first payment for continuation coverage, you will be required to make periodic payments for each subsequent coverage period. The amount due for each coverage period for each qualified beneficiary is shown in this notice. The periodic payments can be made on a monthly basis. Under the Plan, each of these periodic payments for continuation coverage is due on the first of each month for that coverage period. If you make a periodic payment on or before the first day of the coverage period to which it applies, your coverage under the Plan will continue for that coverage period without any break. The Plan will send periodic notices of payments due for these coverage periods.

Grace periods for periodic payments:

Although periodic payments are due on the dates shown above, you will be given a grace period of 30 days after the first day of the coverage period to make each periodic payment. Your continuation coverage will be provided for each coverage period as long as payment for that coverage is made before the end of the grace period for that payment. However, if you pay a periodic payment later than the first day of the coverage period to which it applies, but before the end of the grace period for the coverage period, your coverage under the Plan may be suspended as of the first day of the coverage period and then retroactively reinstated (going back to the first day of the coverage period) when the periodic payment is received. This means that any claim you submit for benefits while your coverage is suspended may be denied and may have to be resubmitted once your coverage is reinstated.

If you fail to make a periodic payment before the end of the grace period for that coverage period, you will lose all rights to continuation coverage under the Plan.

Healthfund Continuation
If you are electing COBRA with a Healthfund and you are a spouse or dependent of an employee who is either remaining active or not electing COBRA then any unused account balances are undivided and allocated between parties following such COBRA election.

Keep Your Plan Informed of Address Changes
In order to protect your and your family's rights, you should keep the Individual Billing Administration informed of any changes to your address and the addresses of family members. You should also keep a copy, for your records, of any notices you send to Individual Billing Administration.

Important Notice
Please examine your options carefully before declining this coverage. You should be aware that companies selling individual health insurance typically require a review of your medical history that could result in a higher premium or you could be denied coverage entirely.

For more information
This notice does not fully describe continuation coverage or other rights under the Plan. More information about continuation coverage and your rights under the Plan is available in your summary plan description or from the plan administrator.

Private sector employees seeking more information about rights under ERISA, including COBRA, the Health Insurance Portability and Accountability Act (HIPAA), and other laws affecting group health plans, can contact the U.S. Department of Labor's Employee Benefits Security Administration (EBSA) at 1 -866-444-3272 or visit the EBSA website at www.dol.gov/ebsa. State and local government employees should contact Maximus, a CMS-sponsored contractor, at www.ContinuationCoverage.net or ContinuationCoverage@maximus.com.

If you have any questions concerning the information in this notice, or your rights to coverage, you should contact Individual Billing Administration at 1-800-429-9526, TDD/TTY: 1-888-899-2562, Monday through Friday 8:00 a.m. to 9:00 p.m. Eastern Time.

Access Our Secure Member Website
If you are electing COBRA continuation coverage and will be retaining the same benefits and dependent coverage you had at the time of your qualifying event (as printed on your election form), you may access MemberIBA.com to initiate your COBRA election. Once enrolled, please visit MemberIBA.com to access your account.

Summary of the COBRA Premium Reduction Provisions under ARRA

President Obama signed the American Recovery and Reinvestment Act (ARRA) on February 17, 2009. ARRA has been amended three times: on December 19, 2009 by the Department of Defense Appropriations Act, 2010, on March 2, 2010 by the Temporary Extension Act of 2010, and on April 15, 2010 by the Continuing Extension Act of 2010. These laws give "Assistance Eligible Individuals" the right to pay reduced COBRA premiums for periods of coverage beginning on or after February 17, 2009 and can last up to 15 months.

To be considered an "Assistance Eligible Individual" and get reduced premiums you:

- MUST have a continuation coverage election opportunity related to an involuntary termination of employment that occurred at any time from September 1, 2008 through May 31, 2010;*
- MUST elect the coverage;
- MUST NOT be eligible for Medicare; AND
- MUST NOT be eligible for coverage under any other group health plan, such as a plan sponsored by a successor employer or a spouse's employer.**

* The involuntary termination must occur on or after March 2, 2010 but by May 31, 2010 if it is preceded by a qualifying event that was a reduction of hours occurring at any time from September 1, 2008 through May 31, 2010.

• IMPORTANT •

◊ If, after you elect COBRA and while you are paying the reduced premium, you become eligible for other group health plan coverage or Medicare you MUST notify the plan in writing. If you do not, you may be subject to a tax penalty.

◊ Electing the premium reduction disqualifies you for the Health Coverage Tax Credit. If you are eligible for the Health Coverage Tax Credit, which could be more valuable than the premium reduction, you will have received a notification from the IRS.

◊ The amount of the premium reduction is recaptured for certain high income individuals. If the amount you earn for the year is more than $125,000 (or $250,000 for married couples filing a joint federal income tax return) all or part of the premium reduction may be recaptured by an increase in your income tax liability for the year. If you think that your income may exceed the amounts above, you may wish to consider waiving your right to the premium reduction. For more information, consult your tax preparer or visit the IRS webpage on ARRA at www.irs.gov.

For general information regarding your plan's COBRA coverage and for specific information related to your plan's administration of the ARRA Premium Reduction or to notify the plan of your ineligibility to continue paying reduced premiums, contact: Individual Billing Administration, 151 Farmington Avenue, RW52, Hartford, CT 06156-7622, or call 1-800-429-9526, TDD/TTY: 1 -888-899-2562, Monday through Friday 8:00 a.m. to 9:00 p.m. Eastern Time.

If you are denied treatment as an "Assistance Eligible Individual" you may have the right to have the denial reviewed. For more information regarding reviews or for general information about the ARRA Premium Reduction go to: www.dol.gov/COBRA or call 1-866-444-EBSA (3272).

** Generally, this does not include coverage for only dental, vision, counseling, or referral services; coverage under a health flexible spending arrangement; or treatment that is furnished in an on-site medical facility maintained by the employer.

To apply for ARRA Premium Reduction, complete this form and return it to us. You may also want to read the important information about your rights included in the "Summary of the COBRA Premium Reduction Provisions Under ARRA."

SALESFORCE.COM

REQUEST FOR TREATMENT AS AN ASSISTANCE ELIGIBLE INDIVIDUAL

Individual Billing Administration
151 Farmington Avenue, RW52
Hartford, CT 06156-7622

Name and mailing address of employee (list dependents in below fields)
STEVEN LORAIN
432 SUPERIOR WAY
DISCOVERY BAY CA 94514

Telephone Number:

Social Security Number:

If you qualify as an "Assistance Eligible Individual" the 35% COBRA monthly cost will be:

		Rate	Plan	Coverage as of Qualifying Event		Other Rate	
MEDICAL	X	163.53	AETNA OAMC	Insured Only			
DENTAL	X	15.16	DENTAL PPO	Insured Only			
VISION	X	2.24	VISION	Insured Only			
OTHER	X	1.08	ASH MASSAGE THERAPY				
OTHER							
FSA			FSA Monthly Contribution				
35 % Monthly Cost is:		$182.01	**Note: This reflects the cost of all offered benefits.**				

Comments:

To Qualify you must be able to check 'Yes' for all statements below.

	Yes	No
1. The loss of employment was involuntary.	☐	☐
2. The loss of employment occurred at some point on or after 09/01/2008 and on or before 05/31/2010.	☐	☐
3. If the loss of employment was preceded by a qualifying event that was a reduction of hours, the reduction of hours took place at some point between 09/01/2008 and 05/31/10 AND the loss of employment occurred on or after 03/02/2010.	☐	☐
4. I elected (or am electing) COBRA continuation coverage.*	☐	☐
5. I am NOT eligible for other group health plan coverage (or I was not eligible for other group health plan coverage during the period for which I am claiming a reduced premium).	☐	☐
6. I am NOT eligible for Medicare (or I was not eligible for Medicare during the period for which I am claiming a reduced premium).	☐	☐

ADDITIONAL ELECTION PERIOD

If your COBRA continuation coverage relates to an involuntary loss of employment from September 1, 2008 through February 16, 2009 and you were eligible for, but did not elect, COBRA continuation coverage OR you elected but subsequently discontinued COBRA, you may have the right to an additional 60-day election period. You should receive a new election notice with an Election Form which you MUST complete and return. If you believe you should have received this additional notice but have not, contact:

Individual Billing Adminstration
151 Farmington Avenue, RW52
Hartford, CT 06156-7622

I elect to exercise my right to the ARRA Premium Reduction. To the best of my knowledge all the answers I have provided on this form are true and correct.

Signature: ____________________ Date: ________

Print Name: ____________________ Relation to employee: ____________________

Dependent Information (Parent or guardian should sign for minor children)

Name: ____________________ Date of Birth: ________ Relation to Employee: ____________________

1. I elected (or am electing) COBRA: ☐ Yes ☐ No
2. I am NOT eligible for other group health coverage: ☐ Yes ☐ No
3. I am NOT eligible for Medicare: ☐ Yes ☐ No

I elect to exercise my right to the ARRA Premium Reduction. To the best of my knowledge all the answers I have provided on this form are true and correct.

Signature: ____________________ Date: ________

Print Name: ____________________ Relation to Employee: ____________

Name: ____________________ Date of Birth: ________ Relation to Employee: ____________________

1. I elected (or am electing) COBRA: ☐ Yes ☐ No
2. I am NOT eligible for other group health coverage: ☐ Yes ☐ No
3. I am NOT eligible for Medicare: ☐ Yes ☐ No

I elect to exercise my right to the ARRA Premium Reduction. To the best of my knowledge all the answers I have provided on this form are true and correct.

Signature: ____________________ Date: ________

Print Name: ____________________ Relation to Employee: ____________

Name: ____________________ Date of Birth: ________ Relation to Employee: ____________________

1. I elected (or am electing) COBRA: ☐ Yes ☐ No
2. I am NOT eligible for other group health coverage: ☐ Yes ☐ No
3. I am NOT eligible for Medicare: ☐ Yes ☐ No

I elect to exercise my right to the ARRA Premium Reduction. To the best of my knowledge all the answers I have provided on this form are true and correct.

Signature: ____________________ Date: ________

Print Name: ____________________ Relation to Employee: ____________

Use this form to notify your plan that you are eligible for other group health plan coverage or Medicare and therefore not eligible for reduced premiums under ARRA.

SALESFORCE.COM	**Participant Notification**	Individual Billing Adminstration 151 Farmington Avenue, RW52 Hartford, CT 06156-7622

Personal Information

Name and Mailing Address:	Telephone Number
	Identification Number

PREMIUM REDUCTION INELIGIBILITY INFORMATION – Check one

I am eligible for coverage under another group health plan. If any dependents are also eligible, include their names below. Insert date you became eligible_____	☐
I am eligible for Medicare. Insert date you became eligible_____	☐

****IMPORTANT****

If you fail to notify your plan of becoming eligible for other group health plan coverage or Medicare AND continue to pay reduced COBRA premiums you could be subject to a fine of 110% of the amount of the premium reduction.

Eligibility is determined regardless of whether you take or decline the other coverage.

However, eligibility for coverage does not include any time spent in a waiting period.

To the best of my knowledge and belief all of the answers I have provided on this Form are true and correct.

Signature _____ Date _____

Type or print name _____

If you are eligible for coverage under another group health plan and that plan covers dependents you must also list their names here:

_____ _____

_____ _____

_____ _____

_____ _____

EXHIBIT C

10071621:8696.001

COBRA Group Health Benefits Right of Continuation Coverage Election Notice:

Continuation of Group Health coverage is available to you due to the following qualifying event which took effect on:
07/01/2010 Reduction In Hours

EMPLOYER SECTION: (Please provide the following information necessary to ensure proper processing of application.) 5/6 6/30

To: Eligible Continuee Applicant's Name STEVEN LORAIN	Date of this Notice: 06/08/2010 From: (Employer) SALESFORCE.COM
Address 432 SUPERIOR WAY	RECEIVED COBRA Individual Billing Number:
City: DISCOVERY / State: CA / Zip Code: 94514	Control: 883528 / Suffix: 10 / Account: 001 / Plan: 001M / Dental Plan: 883528-10-101
Applicant's Control/Suffix/Account under Aetna Group Plan	JUL 07 2010 Date Group Insurance Terminates: Insurance Termination Date: 06/30/2010 / Dental Termination Date (if different):

To elect COBRA continuation coverage, this election form must be completed, returned by mail to the return address on your cover letter, and post marked no later than 08/29/2010

If you do not submit this completed election form by the date indicated above you may lose your right to elect COBRA continuation coverage. If you do not elect COBRA continuation coverage prior to the date indicated above you may change your mind as long as you furnish this completed election form before the date indicated above. However, if you change your mind after first rejecting COBRA continuation coverage your COBRA continuation will begin on the date you furnish the completed election form.

The initial premium payment must be made within 45 days after the date of the COBRA election by the qualified beneficiary. Payment generally must cover the period of coverage from the date of COBRA election retroactive to the date of the loss of coverage due to the qualifying event. If premiums are not paid by the first day of the period of coverage, claims will not be processed until premium payment is received. Premiums for successive periods of coverage are due on the date stated by the plan administrator with a minimum 30 day grace period for payments. Payment is considered to be made on the date it is sent to the plan administrator.

		Rate	Plan	Coverage as of Qualifying Event		Other Rate
MEDICAL	X	467.24	AETNA OAMC	Insured Only		
DENTAL	X	43.30	DENTAL PPO	Insured Only		
VISION	X	6.39	VISION	Insured Only		
OTHER	X	3.08	ASH MASSAGE THERAPY			
OTHER						
FSA			FSA Monthly Contribution			
Monthly Cost is:		520.01	Note: This reflects the cost of all offered benefits.			

6300 Alm 001 401 VSP MSGF

Comments:

Rates are subject to change periodically. Any adjustments in premium will be reflected on your next monthly statement. After the initial payment you must submit the same monthly payment until you have been advised of a change. If you fail to make the monthly payment within 30 days of its due date, your coverage will cease on that date and cannot be reinstated.

Your initial payment must cover the number of full months from the above insurance termination date through the date your payment is mailed.

MAKE CHECK OR MONEY ORDER PAYABLE TO: AETNA

APPLICANT SECTION: CONTINUATION COVERAGE ELECTION INFORMATION - MUST BE COMPLETED

1. Applicant's Name: (Last,First,Middle Init.) STEVEN LORAIN
2. Applicant's Social Security #:
3. Employee Social Security #:
4. Applicant's Address: 432 Superior Discovery Bay, CA 94505
5. [illegible] 6/4/53
6. Telephone #:
7. I request continuation of: X Medical X Dental X Vision ___ Other X Other ___ FSA — Coverage is for: X Self Only ___ Self & Spouse ___ Self & Child(ren) ___ Family ___ Spouse & Child(ren) ___ Self, Spouse & Child(ren) ___ Child Only ___ Spouse Only
8. I am electing premium reduction through the ARRA: ___ Yes ___ No

If coverage is not elected on behalf of any presently covered dependent, a separate copy of this notice will be sent to your present or former spouse, if any; otherwise, to each covered dependent or his/her legal representative for election if the proper name, relationship, mailing address is provided

Name:	Address:	Relationship:

9. All individuals to be Covered:

Name	Relationship	Social Security Number	Date of Birth	Regularly Attending School (Y/N) *	Primary Care Physician #	Previously Seen? (Y/N)
	SELF					

* List the first name of dependent(s) and the name of the school being attended:

Applicant's Signature: Steven Lorain Election Date/Date Signed: 6/26/10

Company Code: Location Code:

008.071910016

EXHIBIT D

salesforce.com
Success. Not Software.

August 9, 2011

Steve Lorain
432 Superior Way
Discovery Bay, CA 94514

RE: Leave of absence

Dear Steve:

We are in receipt of your doctor's note requesting another extension of your leave through September 30, 2011. The Company has evaluated your request and will not be granting this additional extension. Your Employee Success Business Partner, Tina DiSanto, will reach out to you to discuss this in more detail.

We wish you the best with your recovery,

Lourdes Razo
Employee Success Operations Generalist
Ph. (415)536-5211

EXHIBIT E

salesforce.com
Success On Demand.

PERSONAL & CONFIDENTIAL

8/10/2011

Steven Lorain
5730 Marlin Drive
Discovery Bay, California 094514

Dear Steven:

Per our conversation, your employment with salesforce.com is being terminated effective 8/12/2011 the "Termination Date."

Although it is not required, the Company is prepared to offer you a separation benefit in exchange for the execution of a Confidential General Release of Claims (Agreement). Tina DiSanto, your ESBP will contact you to discuss or you may reach out to her directly at 513.381.4324.

Final Paycheck:
Your final paycheck will include pay through 8/12/2011, as well as any accrued but unused paid time off as of 8/12/2011.

Quarterly Certification:
Please complete and return the Quarterly Certification, provided in your term packet. Return the completed form to your Employee Success Business Partner or in the enclosed envelope. If you have an exception to the Quarterly Certification, please describe it in the space provided at the end of Quarterly Certification. If you prefer, you may also report an issue through our independent third-party reporting mechanism, Ethicspoint, available at www.salesforce.ethicspont.com, toll free in the United States at +1 866.294.3540, or collect outside of the United States at +1 503.726.2414.

COBRA:
Your current health insurance benefits will continue until the end of the month that you terminate employment, if you are currently enrolled in the health plan(s). You will then have the right to elect to continue your health insurance benefits, at your own cost, pursuant to COBRA (a federal law that permits employers to provide continuation of group health coverage to employees who would otherwise lose coverage). If you fail to make a timely COBRA election or fail to make timely payments once you elect COBRA, your COBRA coverage will stop and you will lose health coverage. Information about COBRA will be sent to you from our COBRA Administration firm, Aetna. You should expect to receive your COBRA paperwork about 14 days after your health insurance benefits terminate. If you have any questions regarding COBRA, please contact Aetna COBRA Administration at (800) 429-9526.

Life Insurance:
Your life insurance coverage will end on your termination date. You have the right to convert your group life insurance and supplemental life insurance coverage to individual policies without satisfying any medical evidence requirements. This is known as the conversion privilege. The conversion must be applied within 31 days of termination. If you are interested in converting your group life insurance into an individual policy, please contact Employee Success at employeesuccess@salesforce.com.

401(k):
Please contact Fidelity Investments at 800.835.5097 to determine your 401(k) options. You may also contact the Global Equity Plan Services team at geps@salesforce.com with any questions.

Stock:

Should you have stock options, RSUs or other company-granted stock, please refer to the enclosed closing statement you are receiving as a result of your termination. The closing statement will state the last day you have to exercise any vested stock options. Your stock options will be cancelled at the close of the New York Stock Exchange as indicated on your statement. If you have any questions regarding your stock, please contact the Global Equity Plan Services team at geps@salesforce.com.

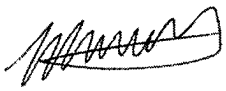
Equipment and Company Property:
All Company equipment including, but not limited to, cell phones, laptops, etc. as well as all Company property, e.g. information regarding customers, etc., must be returned to your manager no later than 8/12/2011. For remote employees, IT will send you a laptop box with return shipment label. You will preserve the information on your hard drive of your computer and agree not to erase or duplicate any of the information contained therein. Failure to return all Company equipment or comply with the provisions of this paragraph will be considered a breach of this Agreement entitling the Company to immediately suspend or terminate all provisions of your separation agreement.

Voicemail / Email:
To protect all Company confidential and proprietary information, your email and voicemail will be deactivated as of 8/12/2011.

Employee Proprietary Information Agreement:
You will be expected to continue to abide by the terms of the Employee Proprietary Information Agreement that you signed when you began your employment with the Company. If you are unaware of your obligations under that agreement you may obtain a copy from your Employee Success Business Partner.

References:
It is the Company's reference policy to provide the date of hire and the date the person left the Company as well as the title of their most recent position. The Company will only provide compensation information if the employee has requested in writing that this information be released. All requests for references should be sent to Employee Success through the Employment Verification line at (415) 536-4556.

Sincerely yours,



Woodson Martin
Sr. Vice President
Employee Success

Enclosures